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THE FUNCTIONS OF THE PSYCHIATRIC HOSPITAL

By WILLIAM C. MENNINGER, M.D.

Psychiatry has been described as functioning on four levels—custodial, therapeutic, preventive, and directional[1]. The psychiatric hospital combines all of these functions in some degree, but from the medical point of view, if it is truly a hospital, the emphasis should be on the therapeutic function. Since, among psychiatric institutions, there exist widely varying degrees of practice on these four levels there are no established standards of organization and personnel comparable to those established for either general or other special hospitals. Ideally the psychiatric hospital is a residential institution, adequately equipped and staffed to provide effective treatment and directional counsel. However, its historical evolution through the jail and the poor house to the asylum, the retreat and finally to the hospital, has been uneven and incomplete. We still have many institutions which are officially labeled hospitals but function only as asylums, with psychiatry practiced chiefly at the custodial level.

The steps in the painfully slow evolution of the alms house of the 18th century into the modern psychiatric hospital of the 20th century are still occasionally in evidence. Some of our state institutions still retain in their names the term "asylum." Some of us who are associated with private psychiatric institutions still retain vestiges of this evolutionary process as indicated in our names of "sanitarium," "retreat" or "haven," either because we have not learned to think of our institution as a "hospital" or perhaps because we wish to make this concession to the misconceptions of the public regarding mental illness. However, the trend is very definitely in the direction of raising the standards of treatment in the psychiatric institution to the same high scientific plane as that achieved by the general hospital, and of recognizing it as and calling it a "hospital."

The function of the ideal psychiatric hospital may occasionally be custodial; always in its relation to the public through every member of its personnel it must be preventive; with the dismissal of every patient it must be directional; in the management of the patients within its doors it must be fundamentally therapeutic.

DYNAMIC PROJECTION OF THESE FUNCTIONS

A hospital differs from a home in that it is especially designed and equipped to promote the recovery of an individual from illness. In other

words, the hospital is fundamentally an especially designed and equipped environment. We have learned in psychiatry that an individual's course through life is essentially a problem of adaptation, of adjustment to a changing and sometimes traumatic environment. When this environment has contained elements or factors which have in some degree overwhelmed the individual he becomes a patient and ideally is removed to that specially created environment in which his ailment can be most effectively treated—the hospital. The effective functioning of the psychiatric hospital must facilitate the recovery from a maladjustment which is expressed primarily by psychological and psychosomatic symptoms. The functions of such a modified environment can be summarized under three major heads: first, protection of the individual against destruction of himself, his family, and his work; second, the simplification of existence for the individual by affording him protection from the factors in the previous environment which precipitated and aggravated his illness; and third, the provision of supportive care, personal contacts and opportunities for expression and psychiatric counsel.

The first stated function, namely the protection of the patient against his possible destruction of himself, his home or his work, is far more inclusive than merely preventing the patient from killing himself. Unfortunately, even under the closest surveillance, suicide will occur in the best psychiatric hospital. The hospital building, however, must be so constructed in its physical equipment, and the personnel so organized and trained that every necessary precaution is taken against such a tragedy. But more than this, the hospital must be managed through its medical and nursing personnel to prevent the many acts of "partial self-destruction,"[2] of which there are many varieties. For example, the staff must prevent the obtaining of intoxicating liquor by the chronic alcoholic addict, the exhaustion in certain anxiety and manic states, the threat of acidosis and attempted starvation in certain schizophrenic and depressed states. All of these and many similar acts must be anticipated and specially planned prophylactic and therapeutic measures instituted to prevent or abort them. In many instances the patient's self-destructiveness is not expressed directly towards himself, but indirectly through the damaging of his reputation, the exasperation of his family or of his friends, or the injury to his business. The psychiatric institution has the function of protecting the patient against such acts, which even though indirect are so destructive to himself.

The second function, the simplification of existence for the patient, is not accomplished merely by placing him in confinement. The psychiatric hospital must be so arranged that it permits the patient to express himself, to live, to reestablish himself, but initially on a much simpler scale than that

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of the environment in which his illness developed. Psychiatrists recognize that the individual's relationships with his immediate family are of primary importance in the causation of his reactions, of the symptoms which comprise his illness. There may be an over-solicitous mother, an alcoholic husband, a domineering father, or a neurotic child to whom the patient is reacting. The hospital has as one of its functions the protection of the patient from these disturbing relationships while he regains his stability. It is a well established fact that the psychiatric patient has a much better opportunity to recover if the relatives are excluded from the immediate environment. The hospital also needs to protect the patient from his well-meaning friends, often against his own wishes or demands. In addition, the hospital can provide a more simplified existence by relieving the patient of some if not most of his usual life responsibilities. The popular conception that mental illness (and sometimes physical illness) offers escape from a difficult situation contains a considerable element of truth. Even though the escaping of responsibility may be a secondary gain of the illness, not infrequently this freedom from responsibility is necessary. Even in those instances where initially the patient may want to carry on a certain amount of his business it is probably best that the hospital prevent this. Later it is also the responsibility of the hospital to hand back to him certain types of responsibility which in the course of his rehabilitation he must gradually assume.

The third function of the psychiatric hospital is inseparably linked with first two, namely the provision of specific and continuous treatment. By *specific* treatment I refer to an especially constructed milieu which meets the psychological needs of the particular individual. By *continuous* treatment I refer to a continuity of effort carried on by every member of the hospital personnel who is in contact with the patient. We must not delude ourselves by thinking that any one procedure like shock therapy, valuable as it is, will revolutionize treatment methods in psychiatry. Even those patients who do benefit from such treatment also need the two major specific elements of therapy provided in a good psychiatric hospital, continuous opportunity for contacts with psychiatrically trained personnel, and opportunity to select from a wide variety of activities appropriate outlets for internal conflicts and psychological needs which have previously found expression in the illness or in symptoms. It is our hates and our mismanaged loves that account for most if not all of our emotional sickness. In other words, our reactions to the people about us and their reactions to us result in adjustment or in varying degrees of maladjustment. Similarly within the hospital, it is the relationships with other human beings—with other patients and with the hospital personnel—and the understanding of these relationships which lead the patient back to emotional health. The

hospital must provide a variety of opportunities for resolution of the patient's conflicts through his expressing his hate in appropriate or constructive ways, in his learning to find new or renewed satisfactions in his activities, in his learning to love and to be loved.

In addition to these functions which deal directly with the patient population, every institution which is rightfully to be regarded and classified as a *hospital* must undertake two additional functions, teaching and research. Every psychiatric hospital has a moral obligation to act as a teaching center, in the sense that its attendants, its nurses, its therapists, its social workers, its physicians must be permanent students of psychiatry, and must present it and promote it as a scientific branch of medicine. It is their responsibility to present it to each other, to their own specialty groups, to physicians in other specialties, to the relatives of their patients, and—perhaps their greatest opportunity—to the community in which they live. There is no other field of medicine in which there are more misconceptions which are at once stigmatizing to the patients, handicapping to every institution, and, worst of all, damaging to the public mental health itself. Teaching outside the institution is usually in proportion to the teaching inside. The rating group of the American Medical Association lists only 76 psychiatric hospitals as acceptable training centers for interns and residents in this field (and an additional 38 psychiatric departments in general hospitals), and the Mental Hygiene Committee's Survey[3] reported that only 43 percent of State Hospitals had interns. Among 224 hospitals reporting in the survey only 21 reported nurses' training schools. The libraries of our psychiatric institutions subscribe to ten medical journals, on the average, though 39.3 percent receive less than this number and only 13.2 percent receive 20 or more. These findings suggest that our average psychiatric institution falls short of the teaching requirements of the ideal *hospital*.

Research involves the responsibility for furthering our knowledge regarding etiology, psychopathology and therapeutic techniques in the field of mental illness. In the report pertaining to research in psychiatric institutions carried out by the National Committee for Mental Hygiene there are some very disconcerting facts regarding such research activities. Less than 20 percent of our public institutions can be designated as research centers, and the present conditions are not favorable for the prosecution of research in 80 percent of 273 public institutions investigated. This status exists despite the fact that the superintendents of such institutions were unanimous in the opinion that research activities tend to quicken the scientific interest of the staff, with consequent improvement in the care and treatment of patients. Furthermore, there are the discreditable findings that less than 10 percent of staff physicians in these institutions show

interest or ability in research and that not a single publication has appeared during the last three years from nearly 50 percent of our state institutions. Any institution which fails to teach or fails to produce research is like the physician who fails to study or fails to use new therapeutic measures. It becomes stagnant and no longer deserves the title of *hospital.*

To restate the functions of the psychiatric hospital, they include (1) protection for the patient; (2) simplification of his environment; (3) the provision of a specific and continuous treatment program; (4) teaching activities; and (5) research.

REQUIREMENTS NECESSARY TO CARRY OUT THESE FUNCTIONS

The first essential to carrying out these functions of the ideal psychiatric hospital is an adequate medical staff—adequate both as to number and as to training. No other specialty of medicine is so undermanned as is that of psychiatry. The standard of the American Psychiatric Association is to have one physician to 150 patients, but there are only 7 institutions out of 224 that meet this standard according to the investigation made by the National Committee for Mental Hygiene. The median for the country is one physician for 293.4 patients and there are nine hospitals which have in excess of 500 patients for each physician. On the basis of my own experience I doubt whether one psychiatrist can actively treat more than 25 patients, and 10 to 12 is better. I say "actively treat" since we cannot regard as adequate treatment running through a hospital ward saying, "Good morning," to attending only to physical needs or even the administration of some type of shock treatment. The number of physicians as well as the attitude toward and the practice of therapy is in some degree a reflection of the medical director of an institution. Unfortunately some of the large institutions which bear the name of "psychiatric hospital" are directed by men who were internists or surgeons or general practitioners in private practice and have had no psychiatric training. The training requirements established by the American Board of Psychiatry and Neurology are highly commendable as an attack upon this problem, as is also the attempt of the American Psychiatric Association to classify its members according to their training, experience and achievement.

The second requirement for the psychiatric hospital is an adequate psychiatrically trained nursing personnel. An institution, to carry out the functions of the hospital discussed above, must have a personnel adequate in number if it is to be actively therapeutic. According to the standards of the American Psychiatric Association the patient load per nurse and attendant should not exceed eight. The findings of the Mental Hygiene survey indicate that the patient load in the average psychiatric institution in this country is 11.8 per nurse or attendant, or 47.5 percent

in excess of the standard load. Only 25 percent of the total number of hospitals investigated measure up to the standard, and in 18 percent more than twice the standard load is found. This survey did not indicate any distinction between graduate nurses and attendants, nor was it possible to establish the amount of training necessary or required for the attendants. I am not unaware of the value and importance—in fact, the economic necessity—of that class of assistants that we call *attendants*, but certainly all of us are aware that in many mental institutions in this country the ward attendant, often called a "supervisor," functions with almost as much authority as a physician, and too often does not have sufficient psychiatric understanding to be a competent attendant. It is unquestionably true that there are many large psychiatric institutions which do not have even a single graduate nurse. It seems to me that any institution caring for sick people which does not provide nursing care under the supervision of a graduate nurse is eliminated at once from the classification of a modern "hospital."

Furthermore, any institution which is to be classed as a *hospital* must carry on a continuous program of psychiatric teaching for attendants, therapists and nurses. Of necessity the nurses and attendants must be an extension of the hand and voice and ears of the physician. Even with a large medical staff this group has far more contact with and responsibility for direction of the patient than any of the staff physicians. Unless they are trained, not only in general medicine but also in descriptive psychiatry and in the elementary facts of dynamic psychiatry, they cannot function intelligently. Even though the physical equipment of the hospital is extremely important it is of minor importance in comparison to a well trained, intelligent, efficient personnel.

The third requirement which an institution must meet in order to function as a *psychiatric hospital* is that of adequate physical equipment which will permit the staff to carry out the many and varied adjunctive therapies which are so valuable for selected cases. Because of the varied demands of different types of psychiatric cases, an institution must be prepared to provide different types of accommodations. Since the patient's daily comfort in living is so important, the physician must be prepared to classify and then separate different types of individuals into small groups. The hospital should be able to provide physiotherapy and occupational therapy under trained, experienced individuals. Only 76 percent of state hospitals have occupational therapy and only 65 percent report having social workers. The hospital should provide an organized recreational therapy program with opportunities for individual activity and not merely mass entertainment. Special educational classes offer a most important therapeutic opportunity. Any institution with over 25 beds calling itself a *hospital*

should have a graduate dietitian, although the fact is that trained dietitians are rare in psychiatric institutions.

A fourth requirement to permit the psychiatric hospital to carry out the above discussed functions is that the hospital have an organization, a material equipment and a scientific plan of study of the patient, through which can be achieved an evaluation of his conflicts, both conscious and unconscious, in the light of his life history and his current life situation. The examination process itself is expensive in effort and time, far more so than in the average medical or surgical case. It entails obtaining a painstaking history from every source available, a physical study, a neurological examination, a laboratory investigation. It requires a psychological investigation which in our own experience cannot be done adequately in less than several hours. After all the data are assembled the psychiatrist must synthesize them in an attempt to understand the significance of the symptoms, and to make a dynamic interpretation of the patient's behavior and attitudes in the light of his life experience. Only on the basis of such a scientific study can we establish a rationale for treating the personality deviations and distortions that are evidenced in the individual's illness.

The fifth requirement in carrying out the functions of the psychiatric hospital is a treatment plan. With all of the scientific study, the physical equipment and the trained personnel, unless we have a *plan* of treatment we must expect poor results. I once heard psychiatry described as that branch of medicine in which a diagnosis is made and the case record filed away. Unfortunately this is still too often the practice, even though there has now been added the magic of shock treatment. It is the rare psychiatric institution where even the thoughtful attempt regarding specificity of treatment compares with the specificity of medical or surgical treatment of a patient in the general hospital. Nevertheless, this should be the aim: a program of psychotherapy, activities, medication and diet specifically prescribed and carried out to meet the physical and the conscious and unconscious psychological needs of each patient. Every psychiatric hospital patient can profit in varying degrees from some form of psychotherapy directly from his physician, and in many instances this is *the* important aid in recovery. Even the mute catatonic patient should have the benefit of a psychiatrist's daily attempt to draw him out of his phantasy world, and, with patient persistence, the psychiatrist may not infrequently be successful. But the physician's contact, even if it be for as long as an hour a day is not adequate for a patient so ill as to require hospital care. There must be an organized milieu, a program of activity which must of necessity be carried out by the psychiatrically trained personnel. The physician's detailed plan of treatment must be such that it can be conveyed

to this personnel through conferences, through the use of an order sheet, and through repeated checking up. The plan must be such that it can be changed frequently and the transmission to such changes be conveyed easily and adequately to the nurses and therapists. Any plan must be sufficiently elastic to permit increases in its field of activity, in its responsibilities, and in its privileges. It must all be directed and constantly supervised by the physician immediately in charge of the patient.

SUMMARY

It has been my purpose to present the functions of an ideal psychiatric hospital and to discuss the requirements which are necessary to make an institution function as a hospital. Psychiatric institutions have made great strides in the last fifty years but the fact remains that the group as a whole urgently needs to raise their standards of organization and to improve their program of therapy. Many institutions call themselves "hospitals" when they have no right by any of the standards herein set forth to regard themselves as such. I am not unaware of the obstacles and the handicaps that have stood and still stand in the road of the progress of the psychiatric institution. But when more than fifty percent of the hospitalized individuals in this country are in psychiatric institutions, I think it behooves every psychiatrist to assume his share of the responsibility in making this field of medicine as scientific and progressive as it can be. I am convinced that those of us connected with psychiatric institutions should assume the responsibility of exposing our own weaknesses and eliminating them. Until such time as we can reach a much more respected state, I believe that this old subject should be kept ever fresh, frequently discussed, and never tabled. I am sure that it is helpful for each of us periodically to map out his own aims, his own purposes, his own functions, and systematically to evaluate his facilities, his abilities and his results.

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FOOD SERVICE AND THERAPY IN A PSYCHIATRIC HOSPITAL

By Leeta Houser, M.S., *Dietitian*

"Good Food is Good Health," is the slogan of the National Restaurant Association. But more than that, the eating of good food is also a fundamental source of pleasure and enjoyment to the majority of individuals regardless of time, place or events. The hospital patient enjoys good food which is prepared well and served attractively just as much as does a guest at a bridge luncheon. And the hospital dietitian who likes her work gains much satisfaction from her efforts to give pleasure in the eating of good food.

In a small psychiatric hospital the dietitian has all the administrative and therapeutic responsibilities which would be given her in any general hospital of like size. However, in carrying out her responsibilities as a therapeutic dietitian, she soon realizes that a change in point of view, emphasis and approach is necessary. Only with such a change in viewpoint can she understand the giving of a special diet order, which is often a special diet in name only. Her concept of illness must be enlarged to include that in which psychological symptoms predominate or even cause physical symptoms. In short, she must become oriented within the field of psychiatry and obtain the psychiatric point of view. This can be done by taking a course in the fundamentals of psychiatry if such is offered by the hospital where she is employed. If not, a series of conferences with the Medical Director, and outside readings suggested by him would be the best alternative. With either arrangement, a short explanation of the case by the physician ordering a special diet is of tremendous importance to the dietitian in carrying out her therapeutic responsibilities. With such an explanation, the dietitian will know whether diet is to be used as a treatment aid for the psychological symptoms of the case or for the physical symptoms (if any). This information is useful to the dietitian in determining how rigidly to enforce the diet order and also in determining the attitude and method of approach to the patient where the matter of diet is concerned.

The administrative responsibilities of the dietitian in a small psychiatric hospital include the every day objectives of any administrative dietitian, i.e., quality food (definitely measured in terms of the budget), good preparation, variety, and attractive service. However, in our hospital, these objectives assume two-fold importance, and the dietitian must experience a more full and consistent realization of these objectives than ever before. Why? Because the food standards of the institution itself are high, because the management and the medical staff want every patient and

employee to be satisfied with the food, because the patients know and are accustomed to good food, because our patients are here for months and sometimes years, and because they have the privilege of giving short orders, by which we mean the ordering of food other than that on the daily menu. Too much short ordering makes for inefficient operation, and so we try to sell our menu to our patients just as surely as any restaurant or hotel tries to sell its speciality of the day to the public. Good food well prepared, variety of menu, appetizing color combinations and attractive arrangement of food on the plate, all play an important part in giving patient satisfaction. The greater the degree of satisfaction, the smaller the number of short orders received and hence the less the food waste.

In addition to the four objectives stated, we try to make our food service as personalized as possible, in so far as the type of illness will permit. The manner in which this is accomplished will become apparent in the ensuing discussion of food service and food therapy for the tray patient and for the dining room patient.

THE TRAY PATIENT

Tray service is necessary for many patients who are not bed patients. Trays are ordered for patients with a tendency to impulsive behavior of a destructive or assaultive nature, for those who are overstimulated by group activity, who are talkative or irritable, who require extensive supervision, who have difficulty making decisions or whose attention is easily distracted.

We use the central type of tray service and a dumb waiter is used as a tray conveyor. This is possible because the two floors receiving tray service are located directly above the kitchen. Thermos jugs of coffee are sent to the floors and coffee is served on the patient's tray just before he receives the tray. Reorders of food, as well as short orders, are permitted.

Because of the fact that very few of our patients are physically ill, the daily menus include a complete range of foods. On the whole, our patients have good appetites and eat well. However, we make every effort to cater to the likes and dislikes of each patient. This is usually done in an indirect way by checking the trays after each meal. When a certain food is left on a patient's tray more than once, a note is made of this so that this food will not be served to the patient in the future. Every tray patient has a card for each meal, and on each card is recorded the floor to which the tray is to be sent, the patient's name, the tray set-up, i.e., whether china and silver or china and one spoon or paper and one spoon, the likes and dislikes of the patient and his choice of beverage for that particular meal. If the patient desires certain foods at breakfast each morning in addition to, or in place of the regular menu, these are indicated on his breakfast card.

When a new patient is admitted to the hospital, the menu is more carefully checked before the first meal is served to this patient. If the menu has on it a food which is not generally liked, the dietitian will ask the nurse to consult the patient as to his liking for the food, providing the nurse feels such action is advisable in the particular case. If not, a substitution will be made anyway, to avoid all chance of serving the patient at his first meal with something which he may not like.

Mrs. A., a new patient, whose order sheet indicated that a general diet be served to her, arrived on the day we happened to have chili for lunch and was served it. Mrs. A. considered herself in poor physical health and furthermore did not like chili. Because of this seeming lack of consideration on our part, she immediately became prejudiced against the food and complained for many days about it.

After each meal, the nurse records on the patient's chart how well he has eaten and also any complaints or comments which he may have made about the food. Such information is then accessible to the patient's physician and is interpreted as a part of the whole picture. The patient may also be uncooperative and unreasonable in other ways. If so, nothing may be done about the food complaints directly.

Physicians and nurses report food complaints and problems to the dietitian. All complaints are solved indirectly if possible, thereby serving to minimize the importance of the complaint. Thus, if it is a matter of service, special requests pertaining to either food or its preparation, or reporting a particularly strong like or dislike, such complaints are taken care of by the dietitian through the kitchen operation. However, if food complaints recur often or continue to grow in number to the exclusion of other complaints, the patient's physician may ask the dietitian to visit the patient and will suggest to the dietitian the attitude to be assumed during the visit. Such a suggestion is valuable even though the dietitian knows something about the symptom picture and reads the order sheet before going to visit the patient.

Example: Mr. D., age 71, height 5′ 4½″, weight 108 pounds, entered the hospital very proud of the fact that he "had been to see all the great specialists in the country and none could recommend the proper treatment" for his condition. They "had seen very few cases like it." The patient was very compulsive and hypochondriacal. He constantly complained of severe pain in the abdominal and genital regions.

Because he was decidedly underweight at the time of admission a high caloric, high vitamin diet was ordered for him. This was useless. There was no point in piling food on the tray of a man who was trying to impress us by recounting at great length what intense abdominal pain he was suffering. Rather, he needed another person to tell the story to, and so the doctor asked the dietitian to visit this patient, listen and before leaving to find out what

he had been used to eating and what he would like to have served to him at the next meal. For several weeks he received only the food which he had said he liked and could eat. Gradually within the next few weeks, the variety of foods was increased until the patient was eating a general diet and complaining very little about the food.

In spite of the fact that the majority of our patients have a good appetite and eat well, we do have feeding problems. In dealing with these problems, the experience of the dietitian in a psychiatric hospital differs greatly from the experience of a dietitian in a general hospital. There, if the problem is one of insufficient food intake to maintain adequate nutrition, the solution usually is found by catering to the likes and dislikes of the patient. On the other hand, if the problem is one of excessive food intake, the solution is to put the patient on a reduction diet. We have both of these problems in a psychiatric hospital but the solutions are more difficult because the causes are deeply underlying ones involving the total personality.

In a psychiatric hospital, if a patient refuses food or eats very little, such refusal may be directly referable to his delusions of unworthiness or to a delusion that the food is poisoned or to the fact that he is too excited to be aware of the food served to him. In the solution of such problems, the dietitian tries to appeal to the appetite by making the trays as attractive as possible, and the servings small. A pretty fruit plate has been used successfully in such an effort. However, the nurse is the important figure in the solution, because of her continuous contact with the patients. With her knowledge of nutrition and her understanding of the motives and mechanisms of behavior, she will recognize eating responses tending toward inadequate nutrition and will seek opportunities for guidance in improving such responses, relying upon her ingenuity as applied to the nurse-patient relationship which she has cultivated. No list of special techniques can be given because each case is different and requires that the nurse's method of conduct be individualized.

Whatever the means employed, suggestion plays a major rôle. It is a constant factor in motivation and in neutralizing strong emotional states. Suggestion, however, is effective only when a state of rapport exists between two individuals, and this state is consciously sought by the nurse. An attitude of understanding and acceptance is fundamental to such a relationship. Such things as watching a patient too closely, oversolicitude and expressions of doubt that the patient will eat are all to be avoided because such precedures may create a negativistic attitude on the part of the patient. Use of fear, either in the form of force or threat, will destroy rapport and hence the effectiveness of any future suggestions given from a different angle of approach.

A patient with delusions of poisoning may be given reassurance by the

nurse if she eats with the patient or tastes the patient's food. Persuasion, argument, and contradiction are to be avoided because they only strengthen the delusion. It is better to ignore, to avoid, or to reassure. Sometimes only special foods are thought to be poisoned, and in this way the issue may be avoided if such information is given to the dietitian.

When a patient refuses food, it is often better to leave him alone with the food than to offer further positive suggestion in any form. However, when this is done, the food is sometimes thrown out of the window or secreted in the room. Incentives, such as permission to become a part of the group again or additional privileges, bring about co-operation in some cases. Before undertaking active assistance, the nurse may offer the patient a reasonable time in which to eat, with the warning that more insistent measures will be adopted if necessary. A time limit is often helpful where patients have a tendency to play around with their food. Sometimes thiamin and insulin are prescribed as medications in an effort to stimulate appetite. A high caloric diet may be ordered with such medication but it is of no value, either psychologically or nutritionally, to increase the amount of food served to a patient until after he has started to eat. Large servings of food are often nauseating to a patient whose appetite is poor.

When all other methods have failed, spoon feeding is considered, but the initiation of spoon feeding is a matter of judgment. It is undertaken earlier with undernourished, easily fatigued patients than with those who are negativistic. Even after spoon feeding has been started, the nurse should be watchful of the first opportunity to withdraw this special attention to feeding. Such an opportunity may present itself with the transfer of the patient to another building. Even with patients who feed themselves such a transfer may be beneficial. In one case, a woman patient who would eat only a few foods, accepted a general diet with little modification after she had moved.

When all normal methods of feeding have failed and the patient's nutritional status is threatened, the method of gavage is used. This is generally performed twice daily, but individual circumstances determine the frequency of feeding. For this reason, the feedings may be used occasionally as supplementary aids or they may be used continually as the only means of securing adequate nutrition for the patient.

A gavage feeding consists of milk, eggs, sugar, molasses, salt, orange juice, and Brewer's yeast. The size and caloric content of the feeding varies with the dietary needs of the individual. Cream may be used to increase the caloric content. Additional vitamin medication should be given if the feedings are continued for any length of time.

To avoid the serious risk of misinterpretation, the purpose of the gavage feedings should be explained before they are started. The patient should

be informed that gavage feedings are necessary for him because adequate nutrition cannot be obtained by his co-operation with more natural methods. The process should be presented as a treatment method which will be discontinued as soon as it is no longer needed. Every precaution must be taken to avoid giving the impression that the treatment is a means of punishment or persecution. The contents of the feedings should be explained to the patient in order to give him additional evidence of concern regarding his nutritional status. Constant opportunity and indirect suggestion to resume natural eating methods is offered by serving meals to the patient throughout the gavage procedure. The patient must understand that if he does not eat after sufficient time has been allowed him, the gavage feeding will be given. Usually the patient is offered the opportunity to drink the formula before gavage is used.

Example: The case of Miss C., age 27, was one in which gavage feedings were frequently used as a supplementary aid to secure adequate nutrition. She had many obsessions and phantasies, hallucinations, was seclusive and her eating habits were marked by suspiciousness regarding her food. Many times she ate only one thing off her tray, leaving the rest. Ten units of insulin were given to her thirty minutes before each meal in an effort to stimulate her appetite. When the insulin was discontinued she stopped eating entirely. After she had left her trays untouched for three days, the doctor told her that if she did not eat it would be necessary to tube feed her. She was quite skeptical about this, claiming she had a sore nose and throat but when she saw this would not help she finally gave up and drank the feeding mixture. That evening she refused to come to her room for the feeding but the doctor surprised her by returning at 10 P.M. to feed her after she was in bed. She took it good-naturedly, however, and after about an hour she drank quite a bit of the feeding herself. Following this episode she ate quite well for a time and the insulin which had been resumed was discontinued. A month or so later she experienced a guilt feeling after throwing some food in the wastebasket and became very worried about two o'clock that night because she thought her doctor might tube feed her as a punishment.

Another case, that of A. K., a young boy of 17, is an illustration of the conditions under which it is necessary for gavage or tube feedings to be given for a period of several months. Upon hospitalization this boy was rigid, and mute except for a word or so each day. For the first few days after his arrival, the nurse attempted to spoon feed him but he would not eat, regardless of time spent with him. He was tube fed for 4 months, but after the first month he was beginning to assist with the process by carrying out the tray after the feeding was given. He still felt that he must not eat because he enjoyed eating so much and felt that he must deprive himself of this enjoyment. He would take nothing by mouth except a few medications, refusing to drink a glass of water with them. The second month he spontaneously drank most of the feedings. The third month it became necessary to use the tube more and more. He was speaking a little more freely by this time, however, and helping to gather up the trays to send back to the kitchen after

meal time. After he began to drink his feedings again, he surprised everyone at lunch time one day by asking for a piece of mince pie which happened to be the dessert for that meal. Within the next 10 days, he ate a little solid food on four occasions. A week later he was taking three meals a day and eating fairly well so that it was only occasionally necessary for him to be tube fed. For three weeks everything went fine. Then he grew more self-derogatory than usual again and ate very little for two days. The doctor talked with him then about the way he was neglecting his health. This did not budge him from his resistive attitude so it was necessary to give a tube feeding. He tried to provoke rough treatment and forceful measures by his resistance to the feeding. Previously he had been very passive and even helpful in the giving of the tube feeding. After the one feeding he started to eat again and ate very well after that. Soon after this a swelling of the gums around several teeth became apparent. He was taken to an oral surgeon who could find no specific cause for this and felt that the changes might be due to malnutrition despite the efforts made to combat this by vitamin fortification of the tube feedings. The oral surgeon and the sanitarium physician who had accompanied the boy presented the situation to him and he promised to help by eating more. His food intake noticeably increased after this. He asked for second helpings and one week gained four pounds. A nutrition class was on the schedule at the time and he became interested in this and started to attend.

Mrs. M., age 47, weight 101 pounds (theoretical weight 128 pounds), entered the hospital with symptoms of extreme nervousness, restlessness, somatic and nihilistic delusions. She refused to eat because she "was not a human being", had "no heart, chest, stomach or intestines, and it was a waste of time." She had to be tube fed for 6 weeks after admission. Then one day she ate a good breakfast and lunch. She ate poorly for the next two months, however. Tube feedings were started again, but the noon trays were cancelled because she was not touching anything on any of the trays served to her. Insulin was given along with the feedings, 7 units about 20 minutes before feeding time. She was more resentful and aggressive because of the feedings than when tube fed for the six weeks after admission. Two months later she started eating again. For the next 6 months she received one or two tube feedings daily, with trays the other one or two meals. Then she started to eat fairly well again. A month later she was still eating poorly, hiding food at times in the dresser drawers. She was tube fed occasionally which distressed her very much. Several months later it was arranged by the nurse for the patient to eat with a group of three or four women on the floor who felt they should like to have her join them. This continued for about a month after which she was asked to eat out by the nurses desk. This distressed her but it was necessary because she repeatedly gave away food when eating with other patients. Several months later she became so much better she was moved to another building and came to the dining room for her meals. She ate very well and her weight gain was 18 pounds.

Up to this point we have considered food intake which is deficient both in calories and protective food because of the fact that the patients will eat very little or nothing at all. In such cases the problem is primarily one of

caloric intake. After the patient starts to eat, the protective foods will automatically become a part of his diet. On the other hand, we frequently have patients whose diet may be adequate in calories but lacking in a number of protective foods because of the many pronounced likes and dislikes of the patients, or their firm belief that they cannot eat certain foods. Alcoholics are the most notable examples of patients with very definite likes and dislikes. They like meats, highly seasoned sauces, spicy foods and the like, but will eat very few vegetables and salads. This is no doubt a reflection of their dulled sense of taste and poor eating habits which have been built up during the years of drinking. Alcoholics are also inveterate drinkers of coffee. They make many demands to the nurse about food and coffee. The nurse informs the dietitian of as many of these requests as may seem advisable in each individual case, and all reasonable requests are granted.

When patients enter the hospital with the belief that they cannot eat certain foods, the physician in charge of the case requests the dietitian to visit these patients, get a list of the foods and serve the patients in accordance with their wishes, whether or not there is a physiological indication that these foods should be omitted from the diet. A patient's acceptance of hospitalization may depend at first upon obtaining such consideration regarding diet. The dietitian may be able to increase the adequacy of the diet by putting some of the lacking protective foods into other foods which will be taken by the patient. Examples of this are putting a beaten egg into orange juice or milk chocolate, putting sieved vegetables and butter into cooked cereals, cream soups or souffles, and other schemes of similar nature. After the patient has been in a psychiatric hospital for a number of weeks, the dietitian, by a little experimentation may be able to increase the adequacy of such a diet less indirectly. Foods which the patient has refused upon admittance if sent up on the tray at a much later date, will sometimes be eaten. Thus, by the addition of foods one by one over a period of weeks, the diet may become a normal adequate diet.

In contrast to those patients whose food intake is insufficient, we have those whose food intake is excessive. Such a patient eats everything served to him at meal time, reorders often, and does much nibbling between meals. He apparently has a continual desire to put something into his mouth. When this goes on until it becomes evident that there has been, or will be, an unhealthy gain in weight, the doctor may order a reduction diet for his patient. However, the advisability of such an order depends upon the individual case and the degree of rapport existing between the doctor and his patient. Until the diet is ordered, the dietitian continues to grant all the patient's requests for food, but she can succeed in decreasing the patient's caloric intake indirectly by making servings smaller.

Example: To show the inadvisibility of ordering a reduction diet until the doctor has begun to gain the patient's confidence, let us consider the case of Mr. X., a 29 year old schizophrenic patient. Mr. X presents a symptom picture of many bizarre and ritualistic mannerisms, and grandiose delusions, and is withdrawn, aloof and preoccupied. To date he has shown no interest in the therapeutic program which we offer, has no constructive interest in doing things or working on any definite project. As yet he is unable to talk with his doctor about any of the events which have led to his present illness and cleverly avoids any attempt on the doctor's part to discuss with him his present ideas or previous experience.

Mr. X. is decidedly overweight for his age and height and in a hospitalization period of 8 months has gained 30 pounds. In one week shortly after being hospitalized he gained 6½ pounds. Mr. X. is very greedy in his eating and when first hospitalized ate everything served to him, including melon and grapefruit rinds.

No reduction diet has been ordered because it is not deemed advisable to deprive him of this oral gratification in eating until an activity has been found which will provide sufficient substitute pleasure.

Pronounced food idiosyncrasies are sometimes observed in patients. These are more than simple likes and dislikes resulting from the dietary habits formed in childhood. Take the case of Miss Y., age 29, for example:

After several days in the hospital it was observed that she did not eat any meat which was served to her, regardless of kind. Upon consultation with the nurse, it was discovered that the patient had been heard protesting many times about the cruelty of people to animals, and she evidently thought it was a crime for them to be killed for use as food. Meat was accordingly omitted from her diet for many weeks. One day it was served to her again and she ate it. This practice was followed intermittently for a week or more, and then it was served to her whenever it was on the menu. This worked for a few weeks and then she began to leave the meat again. Her eating habits were very erratic. At times she ate scarcely anything and at other times she gorged herself with food.

DINING ROOM PATIENT

A patient has the privilege of coming to the dining room when his physician gives an order to that effect. Such an order is given when a patient is well enough to be allowed group privileges and his behavior is acceptable to the group.

Thought to compatibility of interests is given in determining the seating arrangement for patients in the dining room, but men and women are not seated together at the same table.

We have waitress service, but no printed menu. The waitress tells each patient what is on the menu for that particular meal, and the patient may order all or as much of it as he likes, adding any short orders he may wish. If the patient likes and often asks for certain special foods, we try to keep these in stock to be served to him whenever he orders them. This selective

type of service gives the greatest amount of satisfaction possible under our hospital regime, as evidenced by the fact that often a tray patient with many complaints about the food will make very few or no complaints after he starts to eat in the dining room. Moreover, such patients do not give short orders excessively. The very fact that they have the privilege of choosing is the solution of the problem. The change in the emotional setting and the creation of more pleasant associations with food and eating give a psychic stimulation to the appetite which is also a factor in the situation.

Girls of sufficient maturity to know what to do when exceptional incidents occur, whose manner is pleasant and whose appearance is neat and attractive are chosen as waitresses. They are taught to give individual but impartial service, to order the food prepared in the way desired by the patient, to be ready to make possible suggestions to patients if we have something on the menu which the patient does not like and to report to the dietitian any requests for special foods which are not in stock. The waitresses are also given a knowledge of the constituents of an adequate diet, and after they learn to know a patient whose eating habits are poor, they may be able to give guidance by suggestion when opportunities for it present themselves. They are asked to report all such cases to the dietitian, and also to keep her informed about the patients on special diets. The waitresses are also instructed to report to the dietitian any problems or situations arising in the dining room during serving hours, and the manner in which these were handled.

There are definite closing hours for the dining room at each meal time. When a patient starts to the dining room, the nurse gives the patient this information. If a patient comes late to the dining room, through no fault of his own, the nurse calls the dietitian so that the patient will be served. The waitresses are asked to report all late arrivals to the dietitian before telling them that the dining room is closed, unless it is a case in which the patient is habitually late.

SPECIAL DIETS

Special diets are prescribed for their medicinal value or psychological value or both. When a physician wishes to put his patient on a special diet, he calls the dietitian and discusses the case with her for reasons indicated earlier in the chapter. He may also ask her to visit the patient. The physician then leaves an order for the diet in the order book on the ward.

Before a patient is placed on a special diet, it is very important that the physician tell the patient about it, especially if the dietitian has been asked to visit the patient. Some patients are hesitant about accepting a diet different from the others but an explanation from their physician aids

acceptance. This is particularly true of paranoid patients, although it is questionable whether such patients should be on special diets.

Example: Mr. E., 37 years old. Symptoms: depressed, withdrawn and confused; paranoid delusions (afraid unknown persons were trying to harm him or spy on him). At first the patient was extremely reluctant to eat because he feared that his food had been poisoned but when a nurse or someone else would eat some of the food on his tray, he then ate also.

Upon admittance, a high caloric, high vitamin diet was prescribed for this patient. This was given as unobtrusively as possible, since he refused to eat the extra food if he noticed that his tray had something different on it. Sometimes he refused the whole tray. Calories could never be added to the dessert because he refused his unless it was exactly like the others.

A newly admitted patient often has digestive disturbances which disappear quickly as he becomes adapted to his new environment. A soft diet is prescribed for such a patient if the attending physician desires the patient to have food which is easily digested and assimilated.

Soft diets are discontinued after three days and high caloric or high vitamin diets after one month unless reordered by the physician.

In general, special diets prescribed for their medicinal value are the same as those prescribed in a general hospital, but very few types of special diets are necessary, for this reason, in our hospital. The most common types are reduction diets, high caloric and high vitamin diets. A combination of the latter two is often used in the case of alcoholics who frequently present a picture of malnutrition which may even have led to a vitamin deficiency as evidenced in alcoholic polyneuritis.

Special diets are sometimes ordered for psychoneurotic cases. Such a diet order is given principally for its psychological value. There may be a case history of gastro-intestinal difficulties of long standing which upon examination are found to have no physical basis but which have been emotionally induced. From this extended experience of gastro-intestinal trouble, the patient may have become a diet crank and faddist. Such a patient craves having a special diet prescribed for him, and yet such dieting may be harmful to him by acting as a constant suggestion that he is sick. However, the patient will accept hospitalization and become oriented more readily if he is given, at least for the first few weeks, the diet which he has been following previous to admittance. The dietitian is always asked to visit such a patient. The opportunity to tell his dietitic troubles to her is always appreciated by the patient. Later on, the dietitian may be able, indirectly or directly, through interest and suggestion, to add more foods to the diet.

Case Illustration: Mr. N., age 60, entered the hospital 18 lbs. underweight. His symptoms were anxiety, restlessness, lack of concentration and interest in surroundings. No physical findings to speak of except some

pre-senile changes. Upon admission, the patient told his physician that he had always been a "finicky eater" and never able to digest fried food. For this reason and because of his underweight, a high caloric, high vitamin diet eliminating fried foods was ordered. This diet order was followed but evidently it was not special enough for the patient, because he complained about the food. The dietitian was asked to visit him and discovered that he wanted invalid foods, such as poached eggs and cream-of-wheat, served to him. This was done for about three weeks, after which additions were made until the meal served was practically a general diet. Fried pork chops and cottage fried potatoes were almost the only foods omitted.

An example of a diet prescribed for both its medicinal and psychological values would be an "anorexia diet." A patient placed on such a diet is usually a neurotic who is undernourished and completely uninterested in food. The dietitian is asked to visit the patient to indicate that she is interested in him and his welfare. Incidentally she tries to find out about a few dishes the patient likes especially well so that she may be able to tempt his appetite with these. She can visit him again and find out more about his likes and dislikes later on after he has started to eat a little and is more interested in food. Trays sent to such patients should be as attractive as possible both as to food arrangements and color, and the servings should be small.

BETWEEN MEAL NOURISHMENT

Between-meal nourishments consist of fruit juices, milk drinks and fruit baskets which are sent to each floor in the morning and in the evening. The fruit and milk drinks are sent up to the floors in quart and pint bottles and are made up into individual servings there throughout the day. These liquid nourishments are given principally to the patients that need it, i.e., those who do not eat enough at meal time. If the nurse is watchful of opportunities to improve the nutrition of such patients she may be able to get them to take something between meals. Such nourishment, however, should not be given close to meal time.

At night, however, liquid nourishment or fruit is given to each patient in the hospital who desires it. Cookies for everyone are also sent up with the evening nourishments. In the winter months, a hot drink is often prepared in the kitchen by a nurse and sent up to the floors. This has a psychological value in helping to pass away some of the time on a long winter evening and adding to the sociability of the group.

If the patient is trying to gain weight and needs added nourishment between meals, a doctor's order, specifying the food and how much, is necessary.

INTER-DEPARTMENTAL RELATIONSHIPS

Once a week a tea is given at four o'clock in the arts and crafts shop for all the patients who are well enough to go and for any employees able to

leave their work at that time. The occupational therapist has charge of this tea, and a day or so before the tea she confers with the dietitian about the food desired for the occasion. This food is prepared in the kitchen and sent to the Arts and Crafts Shop shortly before tea time.

Sometimes a patient is given the responsibility of planning one of the teas. In this case the patient plans the food and gives this information to the occupational therapist, who, in turn, requests the food from the dietitian. This food is prepared in the kitchen and sent down as before unless the patient, with several others, wishes to prepare the food. In such instances, only raw materials are requested and are sent down for preparation in the small kitchen of the Arts and Crafts Shop.

In addition to preparing tea occasionally, patients wish to do some cooking in the Arts and Crafts kitchen or their physicians may have prescribed such activity for them. For these occasions, supplies are ordered from the kitchen by the occupational therapist. Patients with delusions of food poisoning will sometimes eat if they have a part in the preparation of the food.

Once a week, an evening party for the patients is given at the recreational center by the recreational therapy department. A monthly schedule of such activities is sent out by the department and a copy is given to the dietitian so that she may know sufficiently in advance what the evening parties are to be. Refreshments for the usual weekly parties are planned by one of the recreational therapists who confers with the dietitian a day or so before the party regarding the food desired. Menus for picnics and dinner dances are planned by the dietitian who consults with the recreational therapy department before such menus are decided upon definitely. Sometimes a picnic or dinner dance may be sponsored by a patient. In this case, the patient plans with the dietitian about the food.

The dietitian also gives class instruction to patients in nutrition, buying, experimental cookery and the like when group interests call for it.

SUMMARY

The first aim of all food therapy in a psychiatric hospital is to secure for the patient a state of good nutrition, no matter how much patience and ingenuity is required. In doing this, it is necessary to remember that the eating of food is one of the great universal human pleasures, subject to impairment, distortion, inhibition or total loss, and also to enhancement and exaggeration. To minister wisely to the psychological needs inherent in the taking of food is in many cases just as important as attention to nutritional needs.

To accomplish these two aims is the task of the dietitian, guided by the general principles of dietetics and psychiatry on the one hand, and by special indications in the individual case on the other.

MENNINGER FOUNDATION ACTIVITIES

THE SOUTHARD SCHOOL

Some neurotic children resist all ordinary and even extraordinary treatment efforts. In the home, in the public school, in the private day school, in the boarding school, in the summer camp their behavior makes them exceedingly difficult to manage, disturbing to other children and a source of anxiety to their teachers and parents. Meanwhile they themselves are often miserable, suffering from fears, depressions, alarms, inhibitions, and the consequences of their misbehavior. Such children are sometimes sent to schools for the so-called "exceptional" child, a euphemism used to cover many conditions, such as feeblemindedness and epilepsy, to which the illness of the neurotic child is in no way related psychologically. Many parents would prefer to consider their child "exceptional" and even retarded rather than to face the fact that he is suffering from a neurosis which impels him to exhibit behavior and to endure suffering which is not related to organic deficiencies but to early parental mismanagement.

Experience has shown that such children can be successfully treated, but only under certain optimum conditions. They must be removed from the parental environment and indeed from all of the environment to which their previous behavior was related. They must be provided with an environment which is not only sympathetic, unprejudiced, fair and understanding but which is at the same time so implemented as to enable the proper control and regulation to be set up for the child. Complete avoidance of physical punishment must be insured and in its place provision made for the direct relation of consequences to causes.

To provide such an environment requires intricate and exhaustive planning and the cooperation of specially trained teachers, psychologists, child analysts and psychiatrists. It requires the special adaptation and graduated progression of school curriculum, recreational program, dormitory life, boarding homes and other facilities.

In view of these complicated and expensive requirements, it is no wonder that so few schools of this type have been developed or maintained. The Southard School was established nearly twenty years ago at the suggestion of Professor Ernest Southard of Harvard. For a time it accepted feebleminded children but when experience showed that it was unwise for those treatable neurotic children, no matter how severe, to associate with feebleminded children, no matter how mild, the school's organization and structure were changed and its efforts devoted entirely to the treatment of neurotic children under circumstances whereby they could continue their education and gradually enlarge their social adjustments.

But since most special schools are financially possible only because of the large number of feebleminded children taken for long periods of time, the Southard School soon ran into financial difficulties. In spite of all the need which exists for the special provisions required for such children, the expense involved, the reluctance of the parents to send the child away, and the lack of familiarity on the part of some pediatricians of such opportunities have kept the Southard School enrollment small. A staff of 25 psychiatrists, psychologists, teachers, nurses and others seemed to be the minimum necessary for the proper operation of an adequate program for neurotic children. Such a staff should be able to care for twenty children, but during the past year the services of this many persons have been devoted to the care of a round dozen with a resulting financial deficit of considerable proportions.

A part of this deficit can certainly be charged off to research and pioneer investigation. The patient and intensive work of the staff of the Southard School has enabled it in the past four years to acquire some extremely important scientific material in regard to the character of the personality structure of certain types of behavior problem. The treatment of schizophrenia in childhood, for example, a most discouraging prospect in the eyes of all psychiatrists, has been proved not to be insuperable. Maladjustments characterized by provocative and strongly anti-social behavior which are so difficult to handle by the psychiatrist or child analyst in private practice and so troublesome in the private school or, for that matter, in the public school, have been approached by a new combination of therapeutic measures with encouraging results. These examples are chosen at random from the rich experience derived from a very intensive study of a small number of very interesting children under these auspices.

In recent months the Southard School has made a wider use of boarding homes under the supervision of a psychiatric social worker. Psychotherapeutic conferences, child analysis, special tutoring, progressive project work, manual arts and some other functions are maintained in the central school building, where children too ill for family placement are also boarded. Some of the children attend public schools, with or without supplementary assistance in the central home; others receive all around teaching at the hands of specially trained and daily counselled teachers. Coordinately repetitive psychological tests are given to all children so that each one is studied systematically, not only in cross section but in longitudinal section. The correlation of these psychological findings with the observations of the psychiatrists, analysts and teachers is an illuminating scientific method, some of the results of which are shortly to be published. Along with the research and treatment goes an educational program for psychologists, psychiatrists, teachers and others, some of whom work as residents and internes, while others attend series of lectures and seminars.

To indicate the general nature of the therapeutic results, the following thumbnail sketches of three children have been chosen as representative examples:

A. A., a handsome boy of seven and one-half years, was admitted in August, 1940, because of pyromania, lying, destructiveness, stealing, and truancy from school. In the fall of '40 he began his analysis. During the first year he was tutored at the Southard School and his behavior was both aggressive towards weaker children and destructive. He set several fires, which caused no damage due to the vigilance of the staff; he stole various objects but immediately would show them to one of the staff saying he had found them.

By the fall of 1941 his behavior had improved sufficiently to merit enrolling him in the public school, although he remained in residence at Southard School and continued his analysis. There his behavior has been quite acceptable as has his scholastic work. He has occasionally become involved in fights with other boys but his aggressive behavior towards weaker children has markedly decreased.

In March he moved into a boarding home and has adjusted himself there very well. He keeps the fireplace burning but has set no forbidden fires; he has not truanted from school; his stealing and lying are now rarities.

B. B., a boy of eight, was admitted the fall of 1938 because of irregular, restless movements of his hands and arms, poor motor coordination, and a severe speech defect. He appeared mentally defective, clapping his hands and jumping up and down, unable to express himself verbally. He was accepted because his retardation appeared to be on an emotional basis. Treatment was directed towards intensive speech training, intensive physical training, and psychotherapy.

It was soon discovered that he had many phobias and anxieties which have subsequently been greatly relieved through his psychotherapy. He has learned to read and write, ride a bicycle, and skate. More important is his growing ability to express his thoughts and feelings verbally.

On the Merrill-Terman revision of the Stanford Binet, his I.Q. has increased from 58, in 1938, to 66 in 1941. His first Rorschach test definitely resembled that of a feebleminded child; now it reveals neurotic anxieties which are digressing and indicates his beginning ability to display feelings other than fear.

He had adjusted well to being moved into a boarding home and is asserting himself more aggressively at the school with this additional security.

C. C., a physically well-developed boy of twelve, was admitted in July, 1940. He came from a home in which he had had many advantages, for

his father was a successful professional man. Originally of normal intelligence, over a period of several years his speech had become increasingly unintelligible; he had become more withdrawn, sat in class with his back to the teacher, and suffered from "attacks" during which he would pace back and forth, screaming and weeping. He reacted to suggestions with automatic obedience.

Insulin and metrazol therapy begun soon after his admission had no effect. He began a modified form of psychoanalysis in the fall of 1940, was tutored in class room work, and was given much individual attention by the recreational staff.

At present he is in good contact with people and is able to express his delusional ideas to them; he has had no attacks for many months; and he has progressed in his school work. *In one calendar year* his I.Q., according to the Stanford Binet, increased from 40 to 67, an increase of 4 years, 1 month. In 1940 his Rorschach revealed an organic-like, stereotyped, perseverative picture of immense poverty, showing no affective responses nor free psychomotility. A more recent Rorschach revealed some persistent psychotic elements but also showed him to be a well-endowed, able child in whom affects became free and interest in other human beings now appeared. In spite of this marked improvement he is still too sick to be moved into a boarding home.

It is not to be expected that such a project as this is can be self-supporting. Fortunately, the Southard School has been the beneficiary of generous gifts from the Rockefeller Foundation, Mrs. Lucy Stearns McLaughlin, Mr. Lewis Sterling, and other friends. During the current year (1942) the expected deficit is in the neighborhood of $10,000.00. It has been hoped that a part of this deficit would be met by gifts from interested friends but to date none have been received. After very careful investigation of the work done by the Southard School (which is a *non-profit corporation*, independent of the Menninger Clinic) the executive committee of the Board of Directors of the Menninger Foundation voted to underwrite this deficit.

Contributions intended for the work of the Southard School may be made to the Menninger Foundation, earmarked for this particular project.

BOOK NOTICES

Psychology of Personal Adjustment. By FRED MCKINNEY. Price, $3.50. Pp. 636. New York, John Wiley & Sons, Inc., 1941.

This book is excellent in much of its content, although over-burdened by more than 600 excerpts, citations and references. It is well illustrated with many brief case illustrations. The book's fundamental error lies in a studied and consistent silence as to the contributions of psychiatry to the field, or the interactions of psychology and psychiatry, despite the fact that the author is announced as being associated with the medical department at the University of Missouri. For psychologists to treat psychiatrists as non-existent, whether for reasons of policy or ignorance, does the cause of psychiatric-psychologic cooperation no good. (K. A. M.)

In Defense of Children. By BERT I. BEVERLY. Price $2.00. Pp. 233. New York, John Day Co., 1941.

Doctor Beverly has in a clear, readable manner discussed the development of the child from birth through adolescence. Sufficient factual data is presented on the physical development to enable the readers to better understand the emotional development. The value of this book lies not only in describing the emotional development of the child but also in the number of concrete suggestions made for handling problems as they arise. This is a book which can well be recommended to all parents. (A. R. B.)

Handbook of General Psychology. By W. B. PILLSBURY and L. A. PENNINGTON. Price $1.35. Pp. 400. New York, The Dryden Press, Inc., 1942.

This is a valuable contribution to the handbook literature of psychology. It will be useful for the beginning student as well as for the interested student in other fields. It avoids the two errors most frequently committed in introductory texts, that of offering commonplace statements instead of a factual survey of material, and that of presenting a onesided view of a school or of the author instead of an objective presentation of different views. (D. R.)

Psychiatric Nursing Technic. By A. E. BENNETT and AVIS B. PURDY. Pp. 172. Philadelphia, F. A. Davis Co., 1940.

This is a concise, well written text, containing exactly what the title suggests, usable techniques for nursing the mentally ill. The authors offer many valuable suggestions in regard to observation, contact and daily care of patients. Each chapter is preceded by a good outline of its contents, there are fine illustrations and simple definitions of the more commonly used terms. Specific psychiatric procedures are well covered. As an introductory text for students it is excellent. (M. O. W.)

Unconsciousness. By JAMES G. MILLER. Price $3.00. Pp. 329. New York, John Wiley & Sons, Inc., 1942.

This book is a valuable attempt at clarifying some of the concepts that stood in the way of rapprochement of psychoanalysis and experimental psychology. The book is a pioneer effort and has the deficiencies such efforts are bound to suffer.

The sincere effort at objectivity, the real understanding of the problem and the attempt to bridge the gap between the great realms of psychological investigation recommend it highly. (D. R.)

Shock Treatment in Psychiatry: A Manual. By LUCIE JESSNER and V. GERARD RYAN. Price $3.50. Pp. 149. New York, Grune and Stratton, 1941.

This book presents an excellent short review of insulin, metrazol, and electro shock treatment. The authors have gathered a large amount of material and have condensed it by omitting many of the controversial points in these therapies.

A short historical survey of insulin therapy is followed by sections on technique, complications, changes during treatment, and evaluation of the treatment. In the discussion of metrazol treatment, the authors explain the discrepancy of results by the lack of uniformity in collecting and reporting material. The section on electro shock treatment is not so complete as the others, probably because the material on this phase of shock treatment has not been so completely surveyed as have the other fields.

There is an excellent bibliography, but the book lacks an index. (E. D. G.)

Recent Advances in Neurology. By W. RUSSELL BRAIN. Price $5.00. Pp. 364. Philadelphia, Blakiston Co., 1940. 4th edition.

This issue of the "Recent Advances" series lives up to expectations. There are excellent treatises on the circulation of the cerebrospinal fluid, on headache, and on brain tumors, particularly the vascular tumors, with numerous citations on cerebral angiography as a diagnostic procedure. Electroencephalography receives due consideration. The chapter on intracranial aneurysm is without an equal anywhere in the literature. Functions of the frontal lobes are admirably discussed. There is an excellent organization of the material concerning the virus diseases of the nervous system, as well as the deficiency diseases.

While there is not a great deal that is new in the pharmacology and treatment of muscle disorders, the material is well organized. Chemotherapy of the infections of the nervous system includes only sulfanilamide, because since the book went to press sulfapyridine and sulfathiazole have taken their place in treatment.

The author could have made a little more use of sources in the American literature, notably neurosurgical procedures for the relief of intractable pain and for the relief of the dyskinesias. (H. C.)

Intracranial Tumors of Infancy and Childhood. By PERCIVAL BAILEY, DOUGLASS M. BUCHANAN and PAUL C. BUCY. Price $5.00. Pp. 598. Chicago, University of Chicago Press, 1939.

One hundred consecutive unselected cases of intracranial tumor in infancy and childhood are presented in the greater portion of the book under appropriate diagnostic groupings. The latter chapters of the book are concerned with general pathology, general symptomatology, differential diagnosis, the techniques and results of treatment, and conclusions. The problem of the difference between these tumors and those in adults is admirably treated. The simple, free-flowing style in which the book is

written makes it particularly easy and pleasurable to profit from the wealth of clinical material present. One gains the impression that the authors are too apologetic for the poor results in treatment of most of these tumors. (N. R.)

Psychiatry for Nurses. By LOUIS J. KARNOSH and EDITH B. GAGE. Price $2.75. Pp. 327. St. Louis, C. V. Mosby Co., 1940.

Seventeen of 28 chapters in this book are devoted to description of various clinical psychiatric pictures, with the emphasis on treatment in these illnesses. The other chapters are devoted to history of psychiatry, heredity, personality structure, the causes of mental illness, physiotherapy, occupational and recreational therapy, shock therapy and legal implications in psychiatry. The book is well illustrated with photographs and with case histories, though with a minimal amount of bibliographic documentation. For clinical description of various psychiatric entities and for treatment measures in psychiatric hospitals this book is excellent. (W. C. M.)

Conditioning and Learning. By E. R. HILGARD and D. G. MARQUIS. Pp. 429. New York, D. Appleton-Century Co., 1940.

Much has happened in the field of conditioning since Pavlov's experiments. On the side of the "classical conditioning experiment," which reinforced the response by presenting the unconditioned stimulus, the method of "instrumental conditioning"—using reward and punishment as reinforcing agent—was developed. New theories, like those of Guthrie, Skinner, Hull, Tolman, etc., made conditioning an important issue for the methodology of psychology. This book represents in an objective, scholarly manner the history of conditioning, the views on its place in psychology, as well as the relationship of the different theories. It is a thorough, critical and constructive survey which will be of interest to those who think that conditioning is an important field of psychological research as well as to those who do not think so. (D. R.)

Predicting Success or Failure in Marriage. By ERNEST W. BURGESS and LEONARD S. COTTRELL, JR., Price $2.50. Pp. 472. New York, Prentice Hall, Inc., 1939.

This is the official publication of the authors' much publicized study of the marital adjustments of 526 couples through the questionnaire method, supplemented by some intensive case studies.

A complete questionnaire, consisting of questions regarding the premarital background of both parties, post-marital attitudes, and a personality inventory was statistically analyzed from every possible standpoint. The authors conclude that prediction, in terms of probabilities, before marriage of marital adjustment is feasible. The authors realize that work of this sort requires the complement of individual psychological and psychiatric case studies. (J. F. B.)

Swimming. By R. J. H. KIPHUTH. Price $1.00. Pp. 110. New York, A. S. Barnes & Co., 1942.

The title of this book should be "Competitive Swimming." The real fun and pleasure of swimming is not emphasized in any part of the book. No consideration is given to the mental and emotional aspects of the competitive swimmer. The style of writing is easy to follow and the text is enhanced by many good photographic illustrations. (E. D. G.)